KENTUCKY STATE 30 J-1 VISA WAIVER PROGRAM
PHYSICIAN INFORMATION SHEET

This information sheet must be signed and dated by the physician and returned with all requested documentation by October 31 to:

KENTUCKY DEPARTMENT FOR PUBLIC HEALTH
DIVISION OF ADULT AND CHILD HEALTH
HEALTH CARE ACCESS BRANCH
ATTN: JOHN W. HENSLEY
275 EAST MAIN STREET, HS2GW-A
FRANKFORT, KENTUCKY 40621

SECTION I. PERSONAL INFORMATION **DOS CASE #_____**

NAME: (LAST)_____ (FIRST)_____M.I.____

TELEPHONE # Home: (____)_____ Office #: (____) _____

CURRENT MAILING ADDRESS

Street Address: _____ Apt. Number: _____

City: _____ State: _____ Zip Code: _____

Specialty: _____ Subspecialty: (If Applicable)_____

PROPOSED SERVICE SITE:

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (___) _____ Fax: (_____) _____

SECTION II: **EDUCATION INFORMATION**

Please complete where applicable starting with the most recent. Please send a copy of any diploma or certificate earned.

Fellowship Training:

Name of Institution: _____

Address: _____

Telephone Number: _____

Start Date: _____ Graduation Date: _____

Certifications Held: _____

Post Graduate Training

Name of Institution: _____

Address: _____

Telephone Number: _____

Start Date: _____ Graduation Date: _____

Certifications Held: _____

Professional Education: Degree: _____ Type: _____

Name of Institution: _____

Address: _____

Telephone Number: _____

Start Date: _____ Graduation Date: _____

License Information:

State of Licensing: _____ License Number: _____
Second State Licensing (if applicable)_____ License Number: _____

SECTION III: J-1 PHYSICIAN WAIVER AGREEMENT

I UNDERSTAND AND AGREE THAT I WILL

1. Provide primary care services (family or general practice, pediatrics, internal medicine, or obstetrics/gynecology), psychiatry, or the approved specialty service on a full time basis (at least 40 hours per week) for at least three years in a Health Professional Shortage Area (HPSA) or a federally designated Medically Underserved Area/ Population (MUA/P) within ninety days of waiver issuance by the INS.
2. Request prior approval for a transfer from the Kentucky Department for Public Health.
3. Accept all patients regardless of method of payment or the ability to pay and will provide services to those who have no health insurance coverage, indigent, Medicaid and Medicare populations and provide a discount for individuals under 200% of the poverty level. Notice of the availability of this discount will be posted in a conspicuous location.
4. Submit a reporting form to the Kentucky Department for Public Health every six months or as often as requested by the Department.
5. Cooperate with Department staff with any site visits, which may be conducted.

I UNDERSTAND AND AGREE

1. The review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the department, any and all employees, agents and assigns from any action made in connection with this request.
2. The entire basis for the consideration of my request is the voluntary policy of the Department and its desire to improve the availability of needed medical care in regions designated by the United States Public Health Services as Health Professional Shortage Areas or Medically Underserved Areas.
3. The Department for Public Health shall not be a party to any contract or employment dispute between the sponsor and the physician. However, the Department shall be notified in the event of any change in the terms of the employment contract or premature termination of the contract.
4. If I willfully fail to comply with the terms of this J-1Visa Waiver Agreement, the Kentucky Department for Public Health may notify the Bureau for Citizenship and Immigration Service (BCIS) in the event of my non-compliance. I declare under the penalties of perjury that the foregoing is true and correct.

SIGNATURE OF PHYSICIAN _____ DATE _____

NOTARY _____ DATE _____